Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1 OF DALLAS
SUITE 1000
9330 LBJ FREEWAY
DALLAS TX 75243

Respondent Name
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-0007-01

MFDR Date Received
September 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the EOBs (1st & 2nd denials), claims, and documentation. The patient was referred for an Initial Behavioral Medicine Consultation which then recommended Individual Sessions. The services were provided and the claims were denied per EOB these are non-covered services because this is not deemed a medical necessity by the payer. CPT code 90806 was preauthorized, #9819995 therefore it is deemed medically necessary."

Amount in Dispute: $ 562.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS maintains its denial of services billed for 06/07/2012 – 06/28/2012 based on extent of injury."

Response Submitted by: ACE, ESIS SOUTH CENTERAL WC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 7, 2012, June 12, 2012, June 19, 2012 and June 28, 2012	90806	$562.36	$531.76

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 50 – These are non-covered services because this is not deemed a medical necessity by the payer
   - Notes/Messages: Payment for further treatment has been suspended based on the results of the IME and or peer review
   - 216 – Based on the findings of a review organization
   - * – Body part mismatch
   - Notes/Messages: Denied: not medically necessary based on the results of the IME and or peer review

Issues

1. Did the requestor obtain preauthorization for the services in dispute?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code § 134.600 "(p) Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."

   Review of the preauthorization letter issued by Coventry Workers' Comp Services documents the following: Preauthorization was approved under Reference No: 9819995 for "Mental Health Therapy 1wk x 6 wks Neck/Uper [sic]/Mid/Lower back, 6 visits, dates of service between 05/24/12-07/24/12."

   28 Texas Administrative Code § 134.600 states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   The requestor seeks payment of CPT code 90806 defined by the AMA CPT Code book as "Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient", rendered on June 7, 2012, June 12, 2012, June 19, 2012 and June 28, 2012. Preauthorization was obtained for the disputed services, therefore, the disputed services will be reviewed pursuant to 28 Texas Administrative Code § 134.203.
2. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor billed CPT codes 90806 and 90889 on June 7, 2012, June 12, 2012, June 19, 2012 and June 28, 2012. The division completed NCCI edits to identify edit conflicts that would affect reimbursement. The following was identified: Payment for Procedure Code 90889 is always bundled into payment for other services not specified and no separate payment is made, per Medicare. No NCCI edit conflicts were identified for disputed CPT code 90806 as a result, the disputed services are reviewed pursuant to 28 Texas Administrative Code § 134.203(c).
3. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

The requestor seeks reimbursement in the amount of $140.59. The MAR amount for CPT code 90806 is $132.94 x 4 dates of service for a total recommended amount of $531.76.

Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $531.76 for dates of service June 7, 2012, June 12, 2012, June 19, 2012 and June 28, 2012.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $531.76.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $531.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 31, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.